



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PATRICK RANDOLPH, PHD
6502 SLIDE ROAD
LUBBOCK TX 79424

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-13-0773-01

MFDR Date Received

NOVEMBER 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment was denied for services listed below. EOBs attached. Reconsiderations were sent I and also denied. See attached. Preauthorization was obtained. See attached. Psychological Assessment is attached. This bill was sent to SORM and received on October 10, 2011 as evidenced by SORM's date stamp. SORM set it back for additional information. LightHouse Behavioral Health resent the bill on 11/15/12. It was never paid and was denied for lack of timely filing..."

Amount in Dispute: \$598.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Further review and confirmation from the Division, the dispute packet shows that the Division received this medical fee dispute request on November 20, 2012 which is past the one year filing deadline pursuant to Rule 133.307(c)(1)(A)."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2011 September 29, 2011	Psychological Interview and Testing	\$598.71	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – The time limit for filing has expired.
 - Per Rule 133.20; a health care provider shall not submit a medical bill later than the 95th day after the date the services provided.

Issues

1. Did the requestor file the request for medical fee dispute resolution within the one year filing deadline?
2. Is the requestor entitled to reimbursement?

Findings

1. The disputed dates of service are September 14, 2011 and September 29, 2011; the request for medical fee dispute resolution was received on November 20, 2012. Review of the documentation submitted by both parties shows there were no related compensability, extent of injury, or liability disputes filed. In accordance with 28 Texas Administrative Code §133.307(c)(1)(A) A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
2. Review of the submitted documentation finds that the request for medical fee dispute resolution was not filed within the one year filing deadline. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 8, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.